

		FOR BHF USE					

LL1

2025

STATE OF ILLINOIS

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

FINANCIAL AND STATISTICAL REPORT (COST REPORT)

FOR LONG-TERM CARE FACILITIES

(FISCAL YEAR 2025)

IMPORTANT NOTICE

THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0032979

Facility Name: Hitz Memorial Home

Address: 201 Bell St Box 79Alhambra62001

County: Madison

Telephone Number: (618) 488-2355Fax #: (618) 488-2361

HFS ID Number:

Date of Initial License for Current Owners: 01/01/1968

Type of Ownership:

X

VOLUNTARY,NON-PROFIT

X

Charitable Corp.

Trust

IRS Exemption Code

PROPRIETARY

Individual

Partnership

Corporation

"Sub-S" Corp.

Limited Liability Co.

Trust

Other

GOVERNMENTAL

State

County

Other

In the event there are further questions about this report, please contact:
Name: Cindy TeftellerTelephone Number: (618) 465-7717
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/2024 to 06/30/2025 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed)

(Type or Print Name) MaKenzie Wilson

(Title) Administrator

(Signed) See Accountant's Preparation Report

(Date)

Paid Preparer

(Print Name and Title) Cindy A. TeftellerPartner

(Firm Name & Address) C.J. Schlosser & Company L.L.C.233 E. Center Dr, Alton, IL

(Telephone) (618) 465-7717Fax #: (618) 465-7710

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
2200 Churchill Rd.
Springfield, IL 62702-3406
Phone # (217) 782-1630

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Hitz Memorial Home # 0032979 Report Period Beginning: 07/01/2024 Ending: 06/30/2025

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>34</u>	Skilled (SNF)	<u>34</u>	<u>12,410</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>33</u>	Intermediate (ICF)	<u>33</u>	<u>12,045</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>67</u>	TOTALS	<u>67</u>	<u>24,455</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
				Medicaid Primary	Medicare Primary					
8	SNF						266	313	579	8
9	SNF/PED									9
10	ICF	1,477	3,825	306		9,633			15,241	10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	1,477	3,825	306		9,633	266	313	15,820	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 64.69%

D. How many bed reserve days during this year were paid by the Department? None (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy) Independent Senior Apartments, Day Care

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care? YES ☒ NO ☐

H. Does the BALANCE SHEET (page 17) reflect any non-care assets? YES ☒ NO ☐

I. On what date did you start providing long term care at this location? Date started 01/01/1968

J. Was the facility purchased or leased after January 1, 1978? YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter certified beds. number of certified beds 34

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☐ NO ☐

Tax Year: N/A (Church) Fiscal Year: 06/30/2025

* All facilities other than governmental must report on the accrual basis.

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	A. General Services	1	2	3	4	5	6	7	8			
1	Dietary	266,294	18,388	5,593	290,275		290,275		290,275			1
2	Food Purchase		114,817		114,817		114,817		114,817			2
3	Housekeeping	101,836	24,814		126,650		126,650		126,650			3
4	Laundry	43,790	8,665		52,455		52,455		52,455			4
5	Heat and Other Utilities			115,484	115,484		115,484	(6,640)	108,844			5
6	Maintenance	60,982	4,656	60,408	126,046		126,046		126,046			6
7	Other (specify):* Security and Trash			57,009	57,009		57,009		57,009			7
8	TOTAL General Services	472,902	171,340	238,494	882,736		882,736	(6,640)	876,096			8
	B. Health Care and Programs											
9	Medical Director			13,000	13,000		13,000		13,000			9
10	Nursing and Medical Records	1,821,414	49,940	150,857	2,022,211		2,022,211		2,022,211			10
10a	Therapy											10a
11	Activities	52,097	1,086		53,183	506	53,689		53,689			11
12	Social Services	46,414		1,012	47,426	(506)	46,920		46,920			12
13	CNA Training											13
14	Program Transportation		2,816		2,816		2,816	(6,376)	(3,560)			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,919,925	53,842	164,869	2,138,636		2,138,636	(6,376)	2,132,260			16
	C. General Administration											
17	Administrative	108,027			108,027		108,027		108,027			17
18	Directors Fees											18
19	Professional Services			28,500	28,500		28,500		28,500			19
20	Dues, Fees, Subscriptions & Promotions			10,510	10,510		10,510	(3,306)	7,204			20
21	Clerical & General Office Expenses	2,327	12,044	66,594	80,965		80,965		80,965			21
22	Employee Benefits & Payroll Taxes			326,373	326,373		326,373		326,373			22
23	Inservice Training & Education			3,195	3,195		3,195		3,195			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			158,836	158,836		158,836		158,836			26
27	Other (specify):*											27
28	TOTAL General Administration	110,354	12,044	594,008	716,406		716,406	(3,306)	713,100			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,503,181	237,226	997,371	3,737,778		3,737,778	(16,322)	3,721,456			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000. SEE ACCOUNTANTS' PREPARATION REPORT
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			155,708	155,708	(21,876)	133,832	(8,386)	125,446			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			12,791	12,791		12,791	(4,801)	7,990			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			168,499	168,499	(21,876)	146,623	(13,187)	133,436			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		19,099	185,487	204,586		204,586		204,586			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			155,793	155,793		155,793		155,793			42
43	Other (specify):* Independent Senior Apartments			68,611	68,611	21,876	90,487		90,487			43
44	TOTAL Special Cost Centers		19,099	409,891	428,990	21,876	450,866		450,866			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	2,503,181	256,325	1,575,761	4,335,267		4,335,267	(29,509)	4,305,758			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' PREPARATION REPORT

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(6,640)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(13)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(4,788)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(2,623)	20		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(683)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(14,762)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (29,509)		\$	30

BHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the
general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (29,509)		37

*These costs are only allowable if they are necessary to meet minimum
licensing standards. Attach a schedule detailing the items included
on these lines.

C. Are the following expenses included in Sections A to D of pages 3
and 4? If so, they should be reclassified into Section E. Please
reference the line on which they appear before reclassification.
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' PREPARATION REPORT

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Political Action Committee Payments	\$ 0	20	1
2	Other Expenses Related to Lobbying Activities			2
3	Eliminate depreciation from capital rate adjustments	(8,386)	30	3
4	Offset income for transportation	(6,376)	14	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(14,762)		49

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Illinois Southern Conference of the United Church of Christ	100%					
See attached listing for members of the Board of Directors						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☒ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES☒ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$0	\$ *	39

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A - None								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Hitz Memorial Home # 0032979 Report Period Beginning: 07/01/2024 Ending: 6/30/2025

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization

Street Address

City / State / Zip Code

Phone Number

Fax Number

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Busey Bank		X	Nsg Facility Mortgage - 62.57%	\$2,209.05	1/15/2021	\$ 665,054	\$ 109,717	1/15/2026	3.9400	\$ 8,003	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$2,209.05		\$ 665,054	\$ 109,717			\$ 8,003	9	
	B. Non-Facility Related*												
10	Busey Bank		X	Nsg Facility Mortgage - 37.43%	\$1,321.47	1/15/21	397,842	65,634	1/15/26	3.9400	4,788	10	
11											(4,788)	11	
12	Interest Income Offset										(13)	12	
13												13	
14	TOTAL Non-Facility Related				\$1,321.47		\$ 397,842	\$ 65,634			\$ (13)	14	
15	TOTALS (line 9+line14)						\$ 1,062,896	\$ 175,351			\$ 7,990	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

SEE ACCOUNTANTS' PREPARATION REPORT

SEE ACCOUNTANTS' PREPARATION REPORT

FACILITY NAME	Hitz Memorial Home	COUNTY	Madison
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CONTACT PERSON REGARDING THIS REPORT _____

A. Summary of Real Estate Tax Cost

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	

B. Real Estate Tax Cost Allocations

C. Tax Bills

Page 10A

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 35,681 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable).
ISL Space, 5,180 sq.ft.
Rental Space, 5,726 sq.ft.

F. List the bed capacity for the building if it differs from the licensed total. N/A
G. Have you properly capitalized all major repairs and equipment purchases? Yes
H. Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
I. Are you presently operating under a sublease agreement? No
J. Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?
YES NO X If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over.
N/A

K. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

1		2	3	4	
Use		Square Feet	Year Acquired	Cost	
1	Facility		1976	\$ 45,384	1
2					2
3	TOTALS			\$ 45,384	3

Facility Name & ID Number Hitz Memorial Home

0032979

Report Period Beginning:

07/01/2024

Ending:

06/30/2025

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4				1970	\$ 176,881	\$	40	\$	\$	\$ 176,881	4	
5				1975	418,286		40			418,286	5	
6				1991	1,436,697	35,917	40	35,917		1,237,821	6	
7											7	
8											8	
	Improvement Type**											
9	Improvements			1971	19,945		40			19,945	9	
10	Improvements			1972	90		10			90	10	
11	Improvements			1974	23,177		40			23,177	11	
12	Improvements			1976	81,417		40			81,417	12	
13	Improvements			1977	6,650		40			6,650	13	
14	Improvements			1979	3,000		40			3,000	14	
15	Improvements			1980	15,638		40			15,638	15	
16	Improvements			1982	2,416		40			2,416	16	
17	Dining Room			1985	28,447	474	40	474		28,447	17	
18	Architecture Fees/Improvement			1988	8,001	200	40	200		7,418	18	
19	Solarium & Architecture Fees			1989	67,025	1,676	40	1,676		60,462	19	
20	Remodeling & New Garage			1990	29,672	219	30-40	219		28,579	20	
21	Remodeling/Furnace, Control Temps Architect Fees			1993	27,992	497	10-40	497		24,262	21	
22	Sprinkler System/ Water Heaters			1994	6,896		10-15			6,896	22	
23	Air Conditioner			1998	5,439	136	40	136		3,683	23	
24	Tank Replacement			1999	14,313		20			14,313	24	
25	Air Conditioner			1999	3,280		20			3,280	25	
26	Door Alarm			1999	1,164		10			1,164	26	
27	Door Alarm			2000	1,563		10			1,563	27	
28	Kitchen Sewer Line			2000	2,721		15			2,721	28	
29	Kitchen Fire Suppression System			2002	8,823		15			8,823	29	
30	Door Oxygen Room			2002	791		10			791	30	
31	Garage Door & Sign			2003	1,691		10			1,691	31	
32	Fire Protection/Water Heaters			2004	9,344		10-15			9,344	32	
33	Door Alarms			2005	2,547		10			2,547	33	
34	Solarium			2006	31,589	790	40	790		14,742	34	
35	Water Heater			2007	4,157		10			4,157	35	
36	Air Conditioner			2007	5,621		10			5,621	36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Hitz Memorial Home

0032979

Report Period Beginning:

07/01/2024 Ending: 06/30/2025

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Alarm System	2007	\$ 3,030	\$	10	\$	\$	\$ 3,030	37
38	Patio Landscaping	2007	1,909	48	40	48		855	38
39	Ramp Remodel	2008	24,570	614	40	614		10,698	39
40	Flooring	2008	3,854		10			3,854	40
41	Nursing Station Remodel	2008	60,345	1,509	40	1,509		25,772	41
42	Water Heater	2008	3,867		10			3,867	42
43	Architect Fee- Nurses Station Remodeling	2008	3,142	78	40	78		1,342	43
44	Fire Protection	2009	15,867		10			15,867	44
45	12x24 Garage	2009	3,820	127	15	127		3,820	45
46	Heating Unit	2010	1,605	62	15	62		1,605	46
47	Heating Unit	2010	1,540		10			1,540	47
48	Heating Unit	2010	1,665		10			1,665	48
49	Evaporator Fan Coil Thermostat	2010	2,585		10			2,585	49
50	Carrier Air Handler	2010	7,650		10			7,650	50
51	Install 3 Plan Sinks w/ Drains, Plumbing, and Cabinets	2011	5,941	297	20	297		4,109	51
52	Architect & Design Fees for Wing Remodel - SNF Suite Wing	2011	16,427	657	25	657		9,090	52
53	Contractor's Materials & Labor Cost- SNF Suite Remodel	2011	500	20	25	20		277	53
54	Flooring Materials & Labor for Wing Remodel - SNF Suite Wing	2011	8,439	422	20	422		5,837	54
55	Door Alarms & Wanderguard System - SNF Suite Wing	2011	9,248	472	15	472		6,542	55
56	Water Heater Mixer Valve Replaced & Installed	2011	4,800		10			4,800	56
57	A/C Unit for Dietary	2012	4,334		5			4,334	57
58	A/C Unit for Dietary	2012	738		5			738	58
59	Water Heater Mixer Valve Replaced & Installed	2001	3,074		15			3,074	59
60	Boiler	2001	10,629		20			10,629	60
61	Sprinkler System	2008	7,520	188	40	188		3,196	61
62	Landscaping	1991	1,755	44	40	44		1,507	62
63	Exterior Lights & Sign	1992	2,911		10			2,911	63
64	New Carpet & Installation	2012	3,675		5			3,675	64
65	11 A/C Units	2012	11,703	93	15	93		11,457	65
66	Nurse Station 2 Compressors	2013	2,196	146	15	146		1,757	66
67	Alarm Door Switches Relay, Panel, and Keypad	2013	2,325		10			2,325	67
68	Generator - Emergency Set	2014	22,450	1,122	20	1,122		12,628	68
69	6 A/C Heat Units	2014	5,949		5			5,949	69
70	TOTAL (lines 4 thru 69)		\$ 2,705,336	\$ 45,808		\$ 45,808	\$	\$ 2,394,810	70

SEE ACCOUNTANTS' PREPARATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Hitz Memorial Home

0032979

Report Period Beginning:

07/01/2024 Ending: 06/30/2025

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,705,336	\$ 45,808		\$ 45,808	\$	\$ 2,394,810	1
2	5 A/C Units	2015	3,918		5			3,918	2
3	Landscaping- North & West Side of Facility	2015	9,820	519	10	519		9,820	3
4	Furnace & AC - Dining Room	2015	7,580		5			7,580	4
5	Asco Transfer Switch	2015	3,400	340	10	340		3,315	5
6	5 PTAC Units	2015	5,471		5			5,471	6
7	Gas Water Heater, 75 Gallon	2015	4,116	412	10	412		4,013	7
8	Flooring	2016	571	57	10	57		528	8
9	Carpet	2016	3,942	197	20	197		1,807	9
10	Alarm Keypad, Multi Ray Unit, Door Switch	2016	757	76	10	76		719	10
11	First Q System - Wanderguard	2016	1,672	167	10	167		1,533	11
12	Main Piping, Couplings in Residential Hallway	2016	1,082	72	15	72		655	12
13	Water Heater	2016	8,400	840	10	840		7,560	13
14	Smoking Starter Shelter, 4x8	2016	2,172	109	20	109		978	14
15	3 PTAC Units	2016	2,388		5			2,388	15
16	Thermostatic Mixing Valves/Plumbing	2016	1,241	124	10	124		1,107	16
17	Water Pump in Generator	2016	754	75	10	75		666	17
18	New Sidewalk	2016	1,050	42	25	42		371	18
19	Firewall Laundry to Dr's Office	2016	5,253	175	30	175		1,532	19
20	Kitchen Valves/ Water Lines	2016	517	52	10	52		453	20
21	Pipe in Dry System	2016	1,893	189	10	189		1,640	21
22	Panels for Fire Protection	2016	2,388	239	10	239		2,070	22
23	Block Heater	2016	916	92	10	92		787	23
24	Commercial Garbage Disposal	2016	1,384	138	10	138		1,176	24
25	Water Heater	2017	1,512	151	10	151		1,273	25
26	Pipes/ Fitting Wet System	2017	1,372	137	10	137		1,144	26
27	Carpet	2017	2,553		5			2,553	27
28	A/C Gas Furnace	2017	7,315	488	15	488		3,983	28
29	Gutters/ Downspouts	2017	3,020	302	10	302		2,416	29
30	Attic Fan Vent	2017	841	56	15	56		449	30
31	Dry System Pressure Switch	2017	562	56	10	56		450	31
32	New Sinks in Bathroom	2017	3,073	154	20	154		1,204	32
33	PTAC - Frigidaire Standard	2017	699		5			699	33
34	TOTAL (lines 1 thru 33)		\$ 2,796,968	\$ 51,067		\$ 51,067	\$	\$ 2,469,068	34

SEE ACCOUNTANTS' PREPARATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Hitz Memorial Home

0032979

Report Period Beginning:

07/01/2024 Ending: 06/30/2025

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 2,796,968	\$ 51,067		\$ 51,067	\$	\$ 2,469,068	1
2	HVAC - Kitchen	2018	4,000	267	15	267		1,978	2
3	Max - Metal Signs	2018	800	80	10	80		593	3
4	Keypads	2018	1,075	108	10	108		771	4
5	Fire Panel Hall 2 (1 of 2)	2018	13,829	1,383	10	1,383		9,796	5
6	Fan Motor/ Blade AC Systems	2018	1,262		5			1,262	6
7	Fire Panel Hall 2 (2 of 2)	2018	28,305	2,830	10	2,830		19,578	7
8	Signs/Frames	2018	690	69	10	69		477	8
9	Signs/Frames	2018	530	53	10	53		367	9
10	A/C System	2018	7,519	501	15	501		3,467	10
11	Water Heater 100 Gal	2018	4,205	421	10	421		2,909	11
12	HVAC	2018	1,361	91	15	91		620	12
13	Signs/Frames	2018	760	76	10	76		513	13
14	Hall 1 Writing	2018	3,975	265	15	265		1,767	14
15	2 PTAC	2018	960		5			960	15
16	1 PTAC Unit	2019	515		5			515	16
17	Wanderguard	2019	27,101	1,807	5	1,807		11,292	17
18	Radiator	2019	3,721	372	10	372		2,326	18
19	Generator	2019	1,010	101	10	101		623	19
20	Blower/ Thermostat in Trane Unit	2019	1,727	173	10	173		1,008	20
21	Lennox A/C Unit and Handler	2019	10,284	1,028	10	1,028		5,999	21
22	Lennox Gas Furnance/ AC	2019	9,958	664	15	664		3,706	22
23	11 PTAC Units	2020	9,660	1,377	5	1,377		9,660	23
24	6 RAB LED Flood Fixtures	2020	3,173	317	10	317		1,507	24
25	Hall 3 Door Maglock	2020	2,881	288	10	288		1,369	25
26	Blower Motor	2020	866	87	10	87		411	26
27	AC Unit	2021	1,544	309	5	309		1,364	27
28	Gas Water Heater	2021	4,155	416	5	416		1,766	28
29	Sprinkler System - Pipe & Fittings Replaced	2021	5,824	582	10	582		2,330	29
30	5 PTAC Units	2021	4,723	945	5	945		4,125	30
31	Upgrade Generator from Manual to Automatic	2022	16,294	3,259	5	3,259		12,492	31
32	Roof Replacement	2023	84,444	8,444	10	8,444		24,630	32
33	Roof Replacement	2023	81,677	8,168	10	8,168		23,142	33
34	TOTAL (lines 1 thru 33)		\$ 3,135,796	\$ 85,548		\$ 85,548	\$	\$ 2,622,391	34

SEE ACCOUNTANTS' PREPARATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 3,135,796	\$ 85,548		\$ 85,548	\$	\$ 2,622,391	1
2	Roof Replacement	2023	48,819	4,882	10	4,882		13,832	2
3	Roof Replacement	2023	75,872	7,587	10	7,587		21,497	3
4	Electric Work for AC/Heat Unit	2023	4,150	415	10	415		1,072	4
5	Mitsubishi Hyper Heat Outdoor Unit	2023	15,600	1,560	10	1,560		3,900	5
6	Mitsubishi Hyper Heat Outdoor Unit	2023	10,395	1,039	10	1,039		2,512	6
7	Replacement Windows	2025	4,691	469	10	469		469	7
8	Water Heaters - Hall 2	2025	19,267	408	10	408		408	8
9	1/2 HP Pump and Valve Replaement for Boiler	2025	4,135	69	10	69		69	9
10	Kitchen Panel Retrofit (Kitchen, Utility, Mechanical, Linen Room)	2025	11,333	94	10	94		94	10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,330,058	\$ 102,071		\$ 102,071	\$	\$ 2,666,244	34

SEE ACCOUNTANTS' PREPARATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 212,679	\$ 19,512	\$ 19,512	\$	5-15	\$ 152,973	71
72	Current Year Purchases	5,799	1,063	1,063		5-15	1,063	72
73	Fully Depreciated Assets	817,185				5-15	817,185	73
74								74
75	TOTALS	\$ 1,035,663	\$ 20,575	\$ 20,575	\$		\$ 971,221	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77	Resident Transportation	2005 Chevy Turtle Top Van	2015	25,000				5	25,000	77
78	Resident Transportation	2008 Ford E-150 Van	2023	14,000	2,800	2,800		5	7,233	78
79										79
80	TOTALS			\$ 39,000	\$ 2,800	\$ 2,800	\$		\$ 32,233	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 4,450,105	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 125,446	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 125,446	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,669,698	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	ISL & Rental Building Impr.	\$ 2,772,353	\$ 70,521	\$ 2,006,693	86
87	ISL & Rental Building Equipment	18,318	1,235	11,114	87
88					88
89	Land - ISL & Rental Building	25,000			89
90					90
91	TOTALS	\$ 2,815,671	\$ 71,756	\$ 2,017,807	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .
-

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: \$ N/A Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' PREPARATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39, 2	# of prescrpts				19,099		19,099	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): X-Ray, Labs, Therapy	39, 3				185,487			185,487	13
14	TOTAL			\$		\$ 185,487	\$ 19,099		\$ 204,586	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' PREPARATION REPORT

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$253,110	\$	1
2	Cash-Patient Deposits	6,740		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance25,000)	268,428		3
4	Supply Inventory (priced at)	22,980		4
5	Short-Term Investments			5
6	Prepaid Insurance	16,154		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$567,412	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	93,402		13
14	Buildings, at Historical Cost	6,275,937		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,092,980		16
17	Accumulated Depreciation (book methods)	(5,803,480)		17
18	Deferred Charges	(4,136)		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$1,654,703	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$2,222,115	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$12,043	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	6,279		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	213,147		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued New Provider Tax	13,999		36
37	Accrued Expenses	22,435		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$267,903	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	175,351		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$175,351	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$443,254	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$1,778,861	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$2,222,115	\$	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,606,175	1
2	Restatements (describe):		2
3	Prior Year Adjustments	13,021	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,619,196	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	159,665	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 159,665	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,778,861	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Hitz Memorial Home

0032979

Report Period Beginning: 07/01/2024

Ending: 06/30/2025

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,747,668	1
2	Discounts and Allowances for all Levels	(83,926)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,663,742	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	193,805	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 193,805	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	64	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	22,200	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 22,264	23
	D. Non-Operating Revenue		
24	Contributions	493,911	24
25	Interest and Other Investment Income***	13	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 493,924	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous	57,969	28
28a	<u>Rent - Independent Living</u>	63,228	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 121,197	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,494,932	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	882,736	31
32	Health Care	2,138,636	32
33	General Administration	716,406	33
	B. Capital Expense		
34	Ownership	168,499	34
	C. Ancillary Expense		
35	Special Cost Centers	273,197	35
36	Provider Participation Fee	155,793	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,335,267	40
41	Income before Income Taxes (line 30 minus line 40)**	159,665	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 159,665	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 310,837.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	804,978.00	45
46	MMAI-Medicaid is the Primary Payer	64,398.00	46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	2,213,982.00	48
49	Medicare Part A	128,090.00	49
50	Other-(specify) <u>Managed Care</u>	141,457.00	50
51	Other-(specify)		51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,663,742	56

SEE ACCOUNTANTS' PREPARATION REPORT

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	299	299	\$ 11,953	\$ 39.98	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,917	9,067	367,761	40.56	3
4	Licensed Practical Nurses	9,339	9,703	346,745	35.74	4
5	CNAs & Orderlies	39,768	42,481	1,024,008	24.11	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	2,493	2,570	52,097	20.27	10
11	Social Service Workers	1,952	2,080	46,414	22.31	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,241	16,923	266,294	15.74	15
16	Dishwashers					16
17	Maintenance Workers	2,305	2,441	60,982	24.98	17
18	Housekeepers	6,798	6,832	101,836	14.91	18
19	Laundry	2,669	2,993	43,790	14.63	19
20	Administrator	1,964	2,100	108,027	51.44	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	96	120	2,327	19.39	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,842	2,080	70,947	34.11	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	94,683	99,689	\$ 2,503,181 *	\$ 25.11	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$ 5,593	1, 3	35
36	Medical Director		13,000	9, 3	36
37	Medical Records Consultant		841	10, 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		1,614	10, 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant		506	11, 6	44
45	Social Service Consultant		506	12, 6	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 22,060		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	475	\$ 31,694	10, 3	50
51	Licensed Practical Nurses	206	10,226	10, 3	51
52	Certified Nurse Assistants/Aides	3,227	106,483	10, 3	52
53	TOTAL (lines 50 - 52)	3,908	\$ 148,403		53

SEE ACCOUNTANTS' PREPARATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

STATE OF ILLINOIS

Facility Name & ID Number

Hitz Memorial Home

0032979Report Period Beginning:07/01/2024Ending:06/30/2025Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name

Function

Ownership

Amount

MaKenzie Wilson

Administrator

0

\$ 108,027

TOTAL (agree to Schedule V, line 17, col. 1)

(List each licensed administrator separately.)

\$ 108,027

B. Administrative - Other

Description

Amount

N/A

\$

TOTAL (agree to Schedule V, line 17, col. 3)

(Attach a copy of any management service agreement)

\$

C. Professional Services

Vendor/Payee

Type

Amount

C.J. Schlosser & Co., LLC

Accounting

\$ 28,500

TOTAL (agree to Schedule V, line 19, column 3)

(For legal fee disclosure, see page 39 of instructions)

\$ 28,500

D. Employee Benefits and Payroll Taxes

Description

Amount

Workers' Compensation Insurance

\$ 23,833

Unemployment Compensation Insurance

12,849

FICA Taxes

186,062

Employee Health Insurance

87,292

Employee Meals

Illinois Municipal Retirement Fund (IMRF)*

Retirement Contribution

14,068

Employee Recognition & Uniforms

2,269

TOTAL (agree to Schedule V, line 22, col.8)

\$ 326,373

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description

Line #

Amount

N/A

\$

TOTAL

\$

F. Dues, Fees, Subscriptions and Promotions

Description

Amount

IDPH License Fee

\$ 1,990

Advertising: Employee Recruitment

Health Care Worker Background Check

620

(Indicate # of checks performed)

Patient Background Checks

Association Dues (total from pg 22, #4)

Dues & Subscriptions

2,302

Bank Charges

2,292

Advertising

683

Less: Public Relations Expense

()

PAC and Lobbying payments

()

All non-allowable advertising

(683)

TOTAL (agree to Sch. V, line 20, col. 8)

\$ 7,204

G. Schedule of Travel and Seminar**

Description

Amount

Out-of-State Travel

\$

In-State Travel

Seminar Expense

N/A

Entertainment Expense

()

(agree to Sch. V, line 24, col. 8)

TOTAL

\$

* Attach copy of IMRF notifications

SEE ACCOUNTANTS' PREPARATION REPORT

**See instructions.

XX. GENERAL INFORMATION:

- (1)

Are nursing employees (RN,LPN,NA) represented by a union?

No
- (2)

Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below.
Use the drop down list to identify the association.

Association Name	Amount
	Total
- (3)

List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.

The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.

	Total
- (4)

EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE
(2 and 3 combined)

	Total
- (5)

Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V.

\$ 11,975 Line 10
- (6)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

Yes If NO, attach a complete explanation.
- (7)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$ 155,793

This amount is to be recorded on line 42 of Schedule V.
- (8)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?

No If YES, attach an explanation of the allocation.

- (9)

Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?

None
- (10)

Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?

Yes For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (11)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$ None Has any meal income been offset against related costs?

None Indicate the amount. \$ N/A
- (12)

Travel and Transportation

a. Are there costs included for out-of-state travel?

No

If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents?

No

If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A

c. What percent of all travel expense relates to transportation of nurses and patients?

100%

d. Have vehicle usage logs been maintained?

Yes

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

Yes

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

N/A

g. Does the facility transport residents to and from day training?

No

Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (13)

Has an audit been performed by an independent certified public accounting firm?

Firm Name: N/A
- (14)

Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?

Yes
- (15)

Has a schedule for the legal fees reported on the cost report been provided by the facility?

See page 39 of the instructions for details. N/A

Attach invoices and a summary of services for all architect and appraisal fees.

HITZ MEMORIAL HOME
INDEPENDENT SENIOR LIVING
ATTACHMENT TO SCHEDULE XX, PAGE 22, #10
6/30/2025

The Independent Senior Living (ISL) apartments make up 5,180 square feet of the building. All costs related to the ISL area are on Schedule V, Line 43 of the cost report. The mortgage interest allocated to the ISL area is eliminated on Schedule VI, Line 14 and detailed on Schedule IX, Line 10. All fixed assets associated with the ISL area are detailed on Schedule XI, Section F.